

FILED AUG 30 1948

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Mrs. Wells Nursing Home 701 S. 17th St.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 months** (Specify whether years, months or days)
In this community **Lifetime**

3. (a) PRINT FULL NAME

George Mammie Buzard

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced, **Widowed**
6. (b) Name of husband or wife **Mammie Buzard**
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **March 19 1874**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
74	5	2	hr. min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Letter Carrier**

11. Industry or business **U. S. Postal Service.**

MOTHER FATHER
12. Name **Benj. F. Buzard**
13. Birthplace **Unknown Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Mimmie E. Nicholson**
15. Birthplace **London England**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss. Dorothy Buzard**
(b) Address **Hillcrest Apt's, St. Joseph, Mo.**
17. (a) **Burial** (b) Date thereof **Aug. 23, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Walter Meierhoffer**
(b) Address **1946 Colhoun St., St. Joseph, Mo.**

19. (a) **8-24-48** (b) **E. E. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **1822 Howard Street**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **21st**
year **1948** hour **11** minute **45 A.M.**
viewed AUG 21st 48

21. I hereby certify that I attended the deceased from **AUG 21st 48**, 19... to... 19...
that I last saw him alive on... 19...
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy**

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) Means of injury **3**
23. Signature **B. W. Tadlock** (M. D. or other) **Coroner**
Address **King Hill Bldg** Date signed **8/23/48**

OCT 18 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed *Albert L. Harrington*

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.